



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Juan F. Quiroz, M.D.

Respondent Name

American Zurich Insurance Company

MFDR Tracking Number

M4-16-1257-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied payment for timely submission even though the original bill was submitted timely on 06/11/2015 with proof of prior submission sent with the second request for payment on 09/24/2015 since the carrier had claimed they had not received the claim for that date of service yet."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 2, 2015	Designated Doctor Examination	\$350.00	\$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §102.4 sets out the guidelines for communications between non-division parties.
3. 28 Texas Administrative Code §133.20 sets out the requirements for submitting a medical bill.
4. 28 Texas Administrative Code §133.210 sets out the requirements for medical documentation.
5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services performed from March 1, 2008 until September 1, 2016.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing has expired.
 - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.

Issues

1. Did American Zurich Insurance Company (Zurich) respond to the medical fee dispute?
2. Are Zurich's reasons for denial of payment supported?
3. Is Juan F. Quiroz, M.D. entitled to reimbursement of the disputed service?

Findings

1. The Austin carrier representative for Zurich is Flahive, Ogden & Latson. Flahive, Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on January 21, 2016. 28 Texas Administrative Code §133.307 states, in relevant part:
 - (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
 - (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of Zurich from Flahive, Ogden & Latson to date. The division concludes that Zurich failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. Dr. Quiroz is seeking reimbursement of \$350.00 for an examination to determine maximum medical improvement performed on June 2, 2015. Sedgwick, an agent of Zurich denied the disputed service with claim adjustment reason codes 29 – “THE TIME LIMIT FOR FILING HAS EXPIRED,” and 937 – “SERVICE(S) ARE DENIED BASED ON HB7 PROVIDER TIMELY FILING REQUIREMENT. A PROVIDER MUST SUBMIT A MEDICAL BILL TO THE INSURANCE CARRIER ON OR BEFORE THE 95TH DAY AFTER THE DATE OF SERVICE.”

28 Texas Administrative Code §133.20(b) states, in relevant part, “Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.”

28 Texas Administrative Code §102.4(h) states:

Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Documentation provided by Dr. Quiroz includes a fax confirmation sheet indicating that the medical bill in question was successfully submitted to Sedgwick at the fax number indicated on the Explanation of Benefits.

28 Texas Administrative Code §133.210(e) states:

It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

The division concludes that Dr. Quiroz submitted a medical bill for the service in question to the insurance carrier within 95 days from the date of service, as required by 28 Texas Administrative Code §133.20(b). This service will be reviewed in accordance with applicable fee guidelines.

3. Per 28 Texas Administrative Code §134.204(j)(2)(A):

If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

Paragraph (3) states, "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation supports that Dr. Weeks performed an evaluation of maximum medical improvement (MMI) and found that the injured employee was not at MMI. Therefore, the maximum allowable reimbursement for this examination is \$350.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$350.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	Laurie Garnes	November 21, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.